enabling people with disabilities	**SERVICE REQUEST FORM – CHILD**	**Please return to:** Ability West Access to Services Dept. Blackrock House Salthill Galway H91 R254 **Tel:** 091-540900

Prior to completion of this form please ensure that points 1 - 5 are adhered to;

1. The child applying is/will be attending a Special School of which Ability West is patron.
2. The child has a diagnosis of an Intellectual Disability or an Intellectual Disability and Autism evidenced by a copy of a Psychological Assessment Report (to include cognitive and adaptive functioning).
3. All other relevant multi-disciplinary reports are provided to support the application.
4. Please ensure the family complete the Multi-Disciplinary (MDT) Additional Information Form for Children: 6 Years old to 11 Yrs. 11 Months or the MDT Additional Information Form for Children: 12 Years old to 17 Yrs. 11 Months.
5. This application must be completed by the referring agency/school/family and received by Ability West following an application to the special school for an educational placement.

INDIVIDUAL INFORMATION

Name of Child:	**Date of Birth:**	**Age:**
Address:		
Gender:	**PPSN:**	
Name of Parent/Guardian 1:	**Date of Birth:**	
Address:		
Email:	**Telephone:**	
Name of Parent/Guardian 2:	**Date of Birth:**	
Address:		
Email:	**Telephone:**	

CURRENT LIVING ARRANGEMENTS

	Yes	**No**	
Lives with Parents/Family:	☐	☐	
Fostering Services:	☐	☐	

ADDITIONAL FAMILY MEMBERS

Name	Relationship to child	Date of Birth	School/Occupation	Receiving Support from other specialist services?

DETAILS OF APPLICATION (PLEASE TICK THE APPROPRIATE BOX)

Type of Application	Yes	No
A new application for a child to attend a special school?	☐	☐
An application for services for a child already attending a special school?	☐	☐
Other (please specify):		

SUMMARY OF NEEDS (PLEASE TICK THE APPROPRIATE BOX)			
Mild Intellectual Disability:	☐	Moderate Intellectual Disability:	☐
Severe Intellectual Disability:	☐	Severe & Profound Intellectual Disability:	☐
Autism:	☐		

Please give details of the diagnosis and any additional disability/needs (e.g. Physical, Sensory, Medical):
What are the main concerns regarding the development of the child?
Details of Aids & Appliances used (if any):
If the child a wheelchair user?

DETAILS OF RESIDENCE
Please give a brief outline of where the family live? (e.g. city, rural, distance from local town etc.)
Please provide directions to the family home from the nearest town:
Eircode:

MEDICAL INFORMATION		
Name of GP:	Telephone:	Medical Card No:

ALLOWANCES (PLEASE TICK THE APPROPRIATE BOX)		
Is the family/family member in receipt of the following	Yes	No
Domiciliary Care Allowance?	☐	☐
Carers Allowance in respect of the child?	☐	☐

CURRENT SERVICE PROVISION	
Name of Agency:	Name of School:
Class Teacher:	Days per week:

DETAILS OF MULTI-DISCIPLINARY INVOLVEMENT				
Multi-Disciplinary Service currently being availed of	Yes	No	Name of Person Involved	Reports Available
Psychology:	☐	☐		
Physiotherapy:	☐	☐		
Social Work:	☐	☐		
Speech & Language Therapy:	☐	☐		
Occupational Therapy:	☐	☐		
Positive Behaviour Support:	☐	☐		

DETAILS OF MULTI-DISCIPLINARY INVOLVEMENT (CONTINUED)				
Multi-Disciplinary Service currently being availed of	**Yes**	**No**	**Name of Person Involved**	**Reports Available**
Nurse:	☐	☐		
Pediatrician:	☐	☐		
Consultant (e.g. Neurology):	☐	☐		
CAMHS:	☐	☐		
Other:	☐	☐		

DETAILS OF CURRENT SHORT BREAKS RESPITE PROVISION				
Service Provision	**Yes**	**No**	**Name/Location**	**Frequency**
Community/Family Support:	☐	☐		
Home Sharing:	☐	☐		
Day Projects/Summer Projects/Social Groups:	☐	☐		
Centre Based Respite:	☐	☐		

Total Annual Cost of all Respite Services Currently Provided: €	**Is this funding transferable:**

SERVICES REQUESTED (PLEASE IDENTIFY ONLY SERVICES AND SUPPORTS THAT ARE ASSESSED AS BEING REQUIRED)		
School:	**Days per week:**	**Support Level:**

Multi-Disciplinary Services Required	**Yes**	**No**	**Reason**
Psychology:	☐	☐	
Physiotherapy:	☐	☐	
Social Work:	☐	☐	
Speech & Language Therapy:	☐	☐	
Occupational Therapy:	☐	☐	
Positive Behaviour Support:	☐	☐	
Nurse:	☐	☐	
CAMHS:	☐	☐	
Pediatrician:	☐	☐	

Short Breaks Respite Services	**Yes**	**No**	**Frequency**	**In Place (Y/N)**
Community/Family Support:	☐	☐		**Yes ☐ / No ☐**
Home Sharing:	☐	☐		**Yes ☐ / No ☐**
Day Projects/Summer Projects/Social Groups:	☐	☐		**Yes ☐ / No ☐**
Centre Based Respite:	☐	☐		**Yes ☐ / No ☐**

FAMILY INVOLVEMENT OF REFERRAL APPLICATION		
Has this Referral been discussed with the family of the applicant?	**Yes ☐**	**No ☐**
Have they consented to the sharing of their information?	**Yes ☐**	**No ☐**

REFERRER INFORMATION (MUST BE COMPLETED BY THE REFERRER)		
Name:	**Role:**	
Address:		
Telephone:	**Email:**	
I have reviewed the application form:	**Yes ☐**	**No ☐**
Psychological Report received:	**Yes ☐**	**No ☐**
Additional Multi-Disciplinary Reports available:	**Yes ☐**	**No ☐**
Additional Information Form for children (6 yrs. old – 11yrs/11 months)	**Yes ☐**	**No ☐**
Additional Information Form for children (12 yrs. old – 17yrs/11months)	**Yes ☐**	**No ☐**
Costings and Budget Information provided:	**Yes ☐**	**No ☐**
Further Information added by Referrer:	**Yes ☐**	**No ☐**
Signature:	**Date:**	

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Date Reviewed at Access to Services Meeting:				
School:	**Days p/w:**		**Support Level:**	
Short Breaks Respite Services	**Yes**	**No**	**Frequency**	**Available (Y/N)**
Community/Family Support:	☐	☐		
Home Sharing:	☐	☐		
Day Projects/Summer Projects/Social Groups:	☐	☐		
Centre Based Respite:	☐	☐		
Multi-Disciplinary Services	**Yes**	**No**	**Available/Waitlisted/To be Referred**	
Psychology:	☐	☐		
Physiotherapy:	☐	☐		
Social Work:	☐	☐		
Speech & Language Therapy:	☐	☐		
Occupational Therapy:	☐	☐		
Positive Behaviour Support:	☐	☐		
Nurse:	☐	☐		
Pediatrician:	☐	☐		
CAMHS:	☐	☐		

FOR OFFICE USE ONLY (continued)			
Recommendations/Comments/Decisions (only roles marked * and services identified as required are necessary to sign off in the table below)			
Role	**Recommendation/Comments /Decision**	**Signature**	**Date**
*** Director of Client Services:**			
*** Assistant Director of Client Services:**			
*** Head of Social Work:**			
*** Head of Psychology:**			
Senior Occupational Therapist:			
Head of Physiotherapy:			
Behaviour Support Manager:			
Speech & Language Therapy Manager:			
Respite & Community Services Manager:			
Manager of Ancillary Services:			

FUNDING – CLIENT SERVICES DIRECTORATE			
Type of Service	**Staff WTE Required**	**Annual Funding Required:**	**Comments**
AW staff support in school:		**€**	
Home Sharing:		**€**	
Community Support:		**€**	
Centre Based Respite:		**€**	
Multi-Disciplinary Staffing:		**€**	
Aids & Appliances:	**N/A**	**€**	
Specific Training (e.g. PEG)		**€**	
Capital Costs:	**N/A**	**€**	
Business Case Required/Status:			
Proposed Commencement Date:			**Review Date:**

SENIOR MANAGEMENT TEAM			
Role	**Recommendation/Comments/Decision**	**Signature**	**Date**
Director of Client Services:			
Director of Finance:			
Director of Human Resources:			
Chief Executive:			
Date of Notification to the Board of Directors:			

REVISION		
REVISION NO:	**DATE:**	**DESCRIPTION OF CHANGE**